COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328

Close Inpatient Episode

Inpatient				**CLIENT I.D.#**	
Last Name:					
First Name:		Middle:			
Discharge Date:		Discharge Time:			
Other Factors:	Physical? Yes ☐ No ☐	DD? Yes ☐ No ☐	Dual?: Yes ☐ No ☐		
Referral Out Code:					
Referral Out Provider:					
Patient Status Code:					

DIAGNOSIS

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V
			☐ 1. Primary Support Group	GAF/CGAS
			☐ 2. Social Environment	
			☐ 3. Educational	
			☐ 4. Occupational	
			☐ 5. Housing	
			☐ 6. Economic	
			☐ 7. Access to Health Care	
			☐ 8. Interaction with Legal System	
Primary:			☐ 9. Other Psychological/Environmental	
Secondary:			☐ 10. Inadequate Information	

Provider Name: _____ Provider Number: _____